RETURN BY 4/1/04

THE LOCAL CHOICE HEALTH BENEFITS PROGRAM
EMPLOYER DATA SHEET

Please complete all applicable information and return this sheet to the address shown below. You will receive a letter confirming the plan(s) to be offered and the monthly premiums for each plan.

You must order your enrollment materials using the attached Materials Order form. Fax your order to the number shown at the top of the order form.

1. **Group Name**_____

2. **Effective Date: From**_____**To**_____

3. **Number of Persons Eligible/Participating**

	Eligible	Participating
Active Full Time Employees		
Active Part Time Employees		
COBRA Eligibles		
Retirees Not Eligible for Medicare		
Retirees Eligible for Medicare		

- **Your definition of Full-Time Employee:**

  _____

- **Your definition of Part-Time Employee (if covered):**

  _____

- **Are members of your Governing Body eligible?**

  ☐ Yes, as full-time ☐ Yes, as part-time ☐ No

- **Have any of your definitions changed since your last renewal?**

  ☐ Yes ☐ No

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
Phone (804) 786-6460 Fax (804) 371-0231

4. Benefit Plan(s) to be offered and Monthly Premium for Each Employee/Retiree. Please check the plan names. Enter the individual premium rates from your proposal for all selected plans, not the total monthly premium for your group.

Choose *either* the Standard Package or the Value Package. Both packages may not be offered. Then select HMO if offered/available.

	Standard Package		Value Package		HMO Plan
	☐Key Advantage ☐Key Advantage Expanded	☐Cost Alliance with Dental	☐KeyShare ☐KeyShare Expanded	☐Value Alliance with Dental	☐Kaiser Permanente (Northern Virginia Only)
Active					
Single	$	$	$	$	$
Employee +1	$	$	$	$	$
Family	$	$	$	$	$
Retirees Not Eligible For Medicare					
Single	$	$	$	$	$
Employee +1	$	$	$	$	$
Family	$	$	$	$	$

Retirees Eligible for Medicare			
	☐Advantage 65	☐Advantage 65 with Dental/Vision	☐Medicare Complementary
Single	$	$	$

5. List Contributions:

Minimum Employer Contribution:

Full-Time, Single: 80% Part-Time, Single: 40% Additional Cost of Dependent Coverage (if required): 20%

No employer contribution is required for dependents if more than 75% of all eligible employees are enrolled.

	Single Employer / Employee		Dual Employer / Employee		Family Employer / Employee	
Active Full Time (FT)	$	$	$	$	$	$
Active Part Time	$	$	$	$	$	$
Retiree without Medicare	$	$	$	$	$	$
Retiree with Medicare	$	$	$	$	$	$

6. I hereby certify that the above information is correct to renew The Local Choice Health Benefits Program.

_____/_____

Group Executive Administrator **(Signature Required)**/Date Print Name & Title

_____/_____

Telephone Fax

_____

Email